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### The downside up? A study of factors associated with a successful course of treatment for adolescents in secure residential care

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# CHAPTER 1

## INTRODUCTION

*Secure residential youth care "...is both incarceration and an alternative to incarceration, a form of control imposed so that care can be given"*  
(Harris & Timms, 1993, p. 4)

This chapter is partly based on:

Harder, A. T., Knorth, E. J., & Boendermaker, L. (2011). Residentiële jeugdzorg in beeld [Residential youth care in the picture]. In J. D. Van der Ploeg, & E. M. Scholte (Red.), *Orthopedagogische probleemvelden en voorzieningen in Nederland [Orthopedagogical problem areas and facilities in the Netherlands]* (pp. 267-285). Antwerpen/Apeldoorn: Garant.

Harder, A. T., Knorth, E. J., & Zandberg, T. (2006). *Residentiële jeugdzorg in beeld: Een overzichtsstudie naar de doelgroep, werkwijzen en uitkomsten [Residential youth care in the picture: A review study of its target group, methods and outcomes]*. Amsterdam: SWP Publishers.

## 1.1 Introduction

In the Netherlands, there are 4.9 million young people (30%) between the ages of 0 and 25 in the total population of 16.3 million people (CBS, 2009). Within this group of young people, about five percent has serious problems, which is associated with a need for long-term and intensive care (Knorth, Nakken, Oenema-Mostert, Ruijsenaars, & Strijker, 2008). The most recent numbers in the Netherlands show that nearly 205,000 young people (4%) in the total population of youth use specialized services, including child and youth care services, mental health care and judicial and correctional services (Knorth & Harder, 2009; Stevens et al., 2009).

Somewhat more than a fifth of the group (21%) that use specialized services is placed into out-of-home care, which includes family foster care and residential child and youth care. Young people in out-of-home care more often stay in residential care than in foster families, despite the fact that the Dutch youth care policy shows a preference for foster family placements over residential placements. Somewhat more than one out of ten young people (11% to 14%) in child and youth care in the Netherlands uses residential care services (Baecke et al., 2009; Knorth, 2005).

Residential care refers to a type of out-of-home care in which young people receive care and treatment for 24 hours a day. The intensity of residential stay can consist of several days a week (semi-residential) to a continuous stay in a residential care center (Harder, Knorth, & Zandberg, 2006). Secure residential care can be seen as the most intensive or restrictive type of residential care. It refers to a type of service in which young people, who are regularly placed under coercion, receive care and treatment in a secured environment.

Within secure residential youth care services in the Netherlands, recently a distinction is made between secure residential care centers, called *Jeugdzorg Plus instellingen* and juvenile justice institutions, called *Justitiële Jeugdinrichtingen* in Dutch. The secure residential care centers function within the context of civil law. These centers can be considered as “locked facilities within the child care system” (Milligan & Smith, 2006, p. 75). Juvenile justice institutions are also locked facilities and can be considered as incarceration, although care is also part of the young people’s stay. These institutions function in the context of juvenile criminal law.

More specifically, the legal context for secure residential care centers is captured in the Dutch Child Care Act (*Wet op de Jeugdzorg* in Dutch). The point of departure in this Act, which came into force on 1 January 2005, is client-focused and needs-led care that is effective and efficient (see article 24(1) of the Act). So, an important intention of youth care in general and secure residential care centers in particular is to meet the needs of young people. The rights of young people in juvenile justice institutions are captured in the Dutch Youth Custodial Institutions Act, which came into force on 1 September 2001 (Liefwaard, 2005). Besides safety, the main points of interest in that

Act are care and treatment of the young people in these institutions (see also Bruning, Liefwaard, & Volf, 2004).

Although these facilities have different legal contexts, we consider both these facilities as secure residential youth care, because in practice both are locked facilities which offer care and treatment for adolescents who often show similar antisocial and acting-out behavior problems (Goderie, 2004). The most recent numbers from the Netherlands show that annually almost 7,000 young people stay in judicial and correctional residential settings, which makes up 3% of the total group of young people using specialized services and almost a third (30%) of the group in residential care (Stevens et al., 2009).

The group of young people in residential care can be aged between 0 and 23 years, and can be divided into a group of children (aged 0 to 12 years) and adolescents (aged from 12 years up) (Van der Ploeg, 2005). Although we will mainly focus on the group of adolescents in the present study, both the term *adolescents, young people* and *youth* will be used to refer to the group of clients that stays in (secure) residential youth care (cf. Harder, Knorth, & Boendermaker, 2011).

## 1.2 Young people in (secure) residential care

During the last decennia residential child and youth care have increasingly become a “last resort” for young people whose problems could not be diminished by other types of care (Hellinckx, 2002). Among the population of young people admitted to residential treatment facilities, the proportion of youth with serious behavioral and emotional problems has increased in recent decades. The problems of these young people have become more complex, and the duration of these problems has increased (Colton & Hellinckx, 1994). Young people in residential care often show a high degree of psychopathology and problem behavior, more so than young people who are placed in other types of care (Cornsweet, 1990; Handwerk, Friman, Mott, & Stairs, 1998; Harder et al., 2006; McDermott, McKelvey, Roberts, & Davies, 2002; Van der Ploeg & Scholte, 2003). Lyman and Campbell (1996) describe this as follows: “The contemporary population of youths being admitted into residential treatment is characterized by chronic, multiple problem behaviors that have not responded well to previous treatment attempts (..). The youngsters appear to have significant skills deficits, such as in academic achievement and social competency. Their families appear to be significant dysfunctional and unstable..” (p. 30).

In particular, secure residential care centers seem to have become a kind of last resort for young people with serious problems. Many studies show that these young people often show serious emotional and behavioral problems, with antisocial and oppositional problems being prominently present (Boendermaker, 1999; Bullock, Little, & Millham, 1998; Vreugdenhil, Doreleijers, Vermeiren, Wouters, & Van den

Brink, 2004). The problems of young people in these facilities are complex and have often started at an early age, causing youth to often have a long history of care (Boendermaker, 1995). Some of these young people are responsible for a large part of juvenile delinquency and at risk of becoming criminal adults, and, therefore, the adolescents in secure residential care are an important target for intervention (cf. Mulder, Brand, Bullens, & Van Marle, 2010).

Concerning the development of offending, the following conclusions are widely accepted (Farrington, 2005, p. 5-6):

- 1) The prevalence of offending peaks in the late teenage years (e.g., ages 15 to 19);
- 2) The peak age of onset is between 8 and 14 and the peak age of desistance from offending is between 20 and 29;
- 3) An early age of onset predicts a relatively long and intensive criminal career;
- 4) There is continuity in antisocial behavior from childhood to the teenage years and to adulthood;
- 5) A small subgroup called “chronic offenders” commit a large fraction of all crimes;
- 6) Offending is multifaceted rather than specialized (e.g., violent offenders are indistinguishable from frequent offenders);
- 7) Most offences up to the late teenage years are committed with others, whereas most offences from age 20 onwards are committed alone;
- 8) Reasons for offending are quite variable up to the late teenage years, while utilitarian motives (e.g., to obtain material goods or for revenge) become increasingly dominant from age 20 onwards;
- 9) Different types of offenses tend to be committed at different ages (e.g., shoplifting before burglary and burglary before robbery);
- 10) Offending becomes increasingly diverse up to age 20: as each new type of crime is added, previously committed crimes continue to be committed, but becomes less diverse and more specialized after age 20.

The first three points described by Farrington (2005) refer to the distinction between the “adolescence-limited” and “life-course persistent” offenders made by Moffitt (1993). This life course development theory of Moffitt is shown in Figure 1.1.

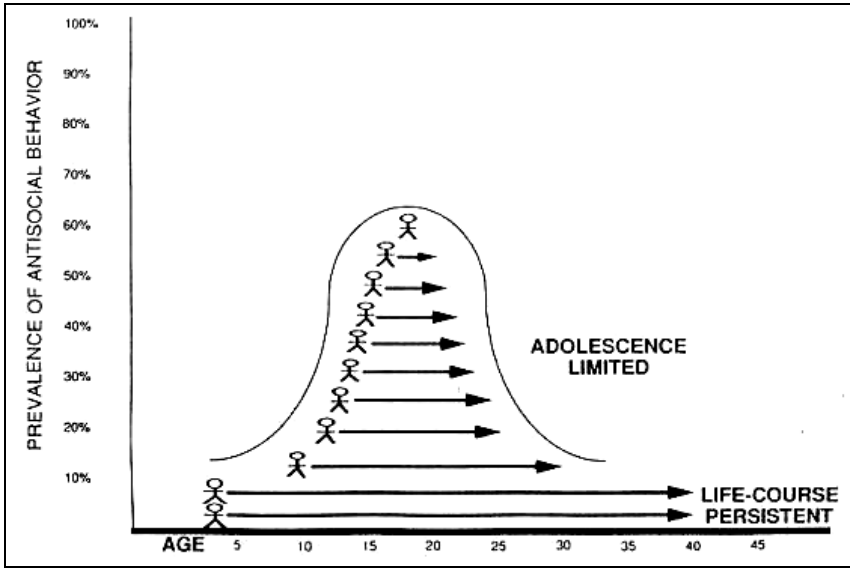


Figure 1.1  
*Antisocial behavior across the life course* (Moffitt, 1993, p. 677)

The theory of Moffitt implies that there are two distinct categories of offenders, each with a unique natural history and etiology. The first group, called life-course persistent, is a small group of offenders that shows antisocial behavior at every life stage. The second group is the largest and consists of individuals that show crime careers with a shorter duration than individuals in the first group (Moffitt, 1993).

Although these findings of both Farrington (2005) and Moffitt (1993) give more insight into delinquent behavior, they provide little explanation about how and why antisocial behavior develops or persists. In this respect, the *risk factors approach*, which is described in many studies and has received substantial empirical support (e.g., Farrington, 2005), provides a better point of departure. In this approach, risk factors are defined as events or conditions that are associated with an increased probability of serious types of delinquency and protective or promotive factors as those factors that are associated with a lowered risk of (serious) delinquency (Loeber, Slot, & Stouthamer-Loeber, 2006). Since events or conditions can imply both risk (e.g., substance abuse) and protection (i.e., the absence of substance abuse), we will use the term promotive rather than protective for the positive end of an independent variable’s distribution, just as Stouthamer-Loeber and colleagues (Stouthamer-Loeber, Loeber, Wei, Farrington, & Wikstom, 2002).

The risk factor approach implies that the development and persistence of the adolescents’ problems in secure residential care can be explained by multiple risk factors (see also chapter two). Research shows that the larger the number of risk

factors and the lower the number of promotive factors, the higher the chance that young people will show problematic behavior (Farrington, 1997; Pollard & Hawkins, 1999; Rutter, Giller, & Hagell, 1998; Steinberg & Avenevoli, 2000; Van der Laan & Blom, 2006a). This association is usually called a “dose-response relationship”, and has been found for several types of antisocial behavior (cf. Loeber et al., 2006).

The risk factors can exist in different life domains of the young people, which are described in the social-ecological model by Bronfenbrenner (1979, see Figure 1.2).

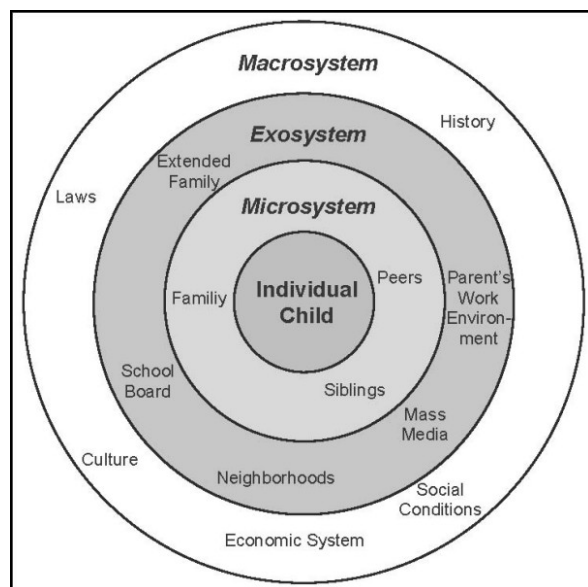


Figure 1.2  
*Bronfenbrenner's social-ecological model, adapted from Niederer et al. (2009)*

Overall, researchers agree to distinguish risk factors in the individual, family, and peer group domain (Dodge & Pettit, 2003; Lahey, Moffitt, & Caspi, 2003; Loeber et al., 2006). Risk factors in different life domains are often linked together (Van der Laan, Van der Schans, Bogaerts, & Doreleijers, 2009), and factors in the individual and family domain (i.e., microsystem) play an important role in childhood (Osofsky & Marshall, 2000), while peers, school and neighborhood become more important in adolescence (Loeber et al., 2006). Research shows that risk factors from each domain contribute to the explanation of why some individuals and not others progress from minor to serious behavior problems (e.g., Farrington, 2005; Loeber, 1998).

Given that the adolescents in secure residential care often show serious and complex problems, they also belong to a group that often shows many risk factors in different domains (Abrantes, Hoffmann, & Anton, 2005; Hussey, Drinkard, Falletta, &

Flannery, 2008). Therefore, a starting point for interventions that have the purpose to reduce the problem behavior of young people, such as secure residential care, is constituted by *dynamic* (changeable) risk and promotive factors, because these factors can be influenced by treatment and can function as guidelines for treatment (Lodewijks, Doreleijers, De Ruiter, & De Wit-Grouls, 2006; Van Domburgh, De Ruiter, & Doreleijers, 2004, see also chapter two).

### 1.3 Outcomes of secure residential care

Considering the complexity and seriousness of the young people's problems, it is not surprising that secure residential care often has limited results in terms of recidivism (cf. Abrams, 2006). Studies carried out in the Netherlands show that 30 to 64% of the young people in secure residential care shows delinquent behavior following secure residential care within one year after their departure (Harder et al., 2006). With the exception of recidivism, there is not much known about the outcomes of secure residential youth care. In the Netherlands, there is one study that showed that the living situation of adolescents after their departure from secure care is often problematic (Boendermaker, 1998). And we are aware of two Dutch studies that focused on the care satisfaction of young people in secure residential care (Beenker & Bijl, 2003; Van Dam, Nijhof, Scholte, & Veerman, 2010).

Positive results may be hard to achieve due to the fact that youth in secure care often show grave and long-standing problems (cf. Boendermaker, 1999; Bullock et al., 1998). Moreover, limitations in the care program such as the absence of an intervention theory, poor implementation of interventions in practice or the use of obsolete methods can restrict positive results (see Van der Laan, 2004; Van Yperen, Van der Steege, Addink, & Boendermaker, 2010).

As is already mentioned, secure residential care refers to care and treatment in a secured or locked environment. Besides a focus on treatment of the admitted adolescents, secure residential care is also aimed at protecting the community for the undesirable behavior of these adolescents. Therefore, Lemmond and Verhaagen (2002) describe secure residential youth care as a type of care that "...allows for intensive focus on treatment, strict control of the youth's environment, and protection for the community.." (p. 2). In the Netherlands, it is a public task of juvenile justice institutions to protect the community. Considering secure residential youth care, a paradox comes up: On the one hand juvenile justice institutions have a correctional task (i.e., retribution for what these young people have done), and on the other hand a treatment and educational task that is aimed at empowering the young people to build a positive living in the community. For adolescents that are placed in secure care within the context of civil law, the residential stay mainly has a protective function for the adolescent and his or her environment. Despite this apparent difference, the final



intention of both types of secure residential care facilities is that the adolescents leave the center in a better condition than at entry.

#### **1.4 Improving outcomes: What works in the black box?**

Residential youth care, and specifically secure residential care, can be perceived as a “black box” because there is scarce information about the contents and quality of residential care (Knorth, 2003; Libby, Coen, Price, Silverman, & Orton, 2005; Sinclair, 2010). The amount of (empirical) research on the contents and/or quality of care in secure residential care is highly limited. Signs that emerge from the Dutch media about the care offered in secure residential youth centers are generally negatively in nature. The few Dutch studies that focused on secure residential care were among others focused on the theoretical orientations applied in the centers (Boendermaker, 1999), the methods applied by group care workers in contact with young people (Wigboldus, 2002), and the care experience of the young people (Boendermaker, 1998; Van der Vlugt & De Jong, 2005). In none of these studies explicit attention has been paid to the characteristics of the care process that are associated with successful care for this specific problematic target group.

Despite the scarce information about which ingredients are important for a good quality of (secure) residential youth care, research has shown several guidelines that are often referred to as “*what works*” principles. In recent years, considerable research attention has been given to the outcomes of care for children and young people, as well as to the ingredients that proved effective in such treatment (Barrett & Ollendick, 2005; Boendermaker et al., 2007; Carr, 2009; Fonagy, Target, Cottrel, Phillips, & Kurtz, 2002; McAuley, Pecora, & Rose, 2006). There are two lines of research that are relevant in a secure residential youth care context, namely studies focusing on what works for antisocial youth and studies focusing on what works in (secure residential) youth care.

##### *1.4.1 What works for antisocial youth*

Important what works aspects for antisocial youth that are often mentioned in this respect are principles of effective programs for reducing recidivism. Based on the findings a meta-analysis of Andrews and colleagues (1990) and several review studies on outcomes of interventions with juvenile delinquents, McGuire (1999) identified the following principles of effective programs (p. 14-15):

- Risk classification, or the “risk principle”, which means that there is a matching between the offender risk level and the degree service intervention: higher-risk individuals receive more intensive services, whereas low-risk individuals receive lower intensive services.

- Criminogenic needs, which are also called the “needs principle”, states that it is essential to distinguish between criminogenic and non-criminogenic needs. Interventions should be focused on those client factors that are the foundations of the problem behavior.
- The “responsivity principle” means that there should be an appropriate matching between styles of workers and styles of clients.
- The “treatment modality principle” refers to the finding that interventions should be aimed at different aspects of the clients’ problems (multimodal) and therefore should apply different methods. Also, skills-oriented programs and programs using behavioral, cognitive or cognitive-behavioral methods were found to be the most effective.
- Program integrity, which means that effective programs are those in which the stated aims are linked to the methods being used, including the availability of adequate resources to achieve these aims, appropriate training and support of staff, and an agreed-upon planning for program monitoring and evaluation.

McGuire (1999) also consider community based programs, which are located in the community and close by the individuals’ home environments, as more effective than institution-based services, but also mentions that this point requires further clarification and amplification. A more recent meta-analytical review of Lipsey (2009), however, shows that the context of the intervention (i.e., residential or non-residential) does not make a difference regarding the outcomes of interventions for juvenile offenders. He found three important factors that contributed to program effectiveness, namely a “therapeutic” intervention philosophy, specific interventions focusing on high risk offenders with aggressive/violent histories, and interventions that were implemented with a high quality, or to put it differently, interventions with good program integrity (Lipsey, 2009).

#### *1.4.2 What works in (residential) youth care*

Studies focusing on what works in (secure residential) youth care often refer to the so called non-specific and specific treatment factors (Van Yperen et al., 2010). Non-specific factors are those factors that affect the services offered, regardless of the target group or the type of services. Specific treatment factors are only operating with regard to certain types of intervention and certain target groups (e.g., Duncan, Miller, Hubble, & Wampold, 2010).

Non-specific factors are for example client factors and relationship factors between the client and therapist. Client factors consist of the factors that are part of the client, such as the severity of the problems, the clients’ strengths and motivation for treatment, and factors that are part of the environment, such as supportive elements in their environment. The relationship factors refer to the therapeutic

relationship, which is most commonly defined as an emotional connection (e.g. affective attachment, affective bond, social support) and/or a cognitive connection in terms of agreement on the tasks and goals of therapy (Karver, Handelsman, Fields, & Bickman, 2005), and encompasses variables that are found in a variety of therapies regardless of the therapist's theoretical orientation (Daniël & Harder, 2010; Duncan et al., 2010). Important therapist factors related to the client-therapist relationship are for example a client-centered attitude, communication- and listening skills and self reflection (Ackerman & Hilsenroth, 2003; Van der Steege, 2003; Van Erve, Poiesz, & Veerman, 2005). Norcross (2010) describes the therapists' contribution as follows: "on the therapist side, foster a stronger alliance by using communication skills, empathy, openness, and a paucity of hostile interactions" (p. 121).

Client and relationship factors are considered to be the most important predictors of positive outcomes in child and youth care (Carr, 2009; Karver, Handelsman, Fields, & Bickman, 2006). Because adolescents in secure residential care are regularly placed under coercion, often unaware of their problems and resistant to change (i.e., showing a lack of motivation for treatment), client and relationship factors seem to be especially important for achieving positive outcomes in the context of secure residential care (cf. Lodewijks, 2007; Van Binsbergen, Knorth, Klomp, & Meulman, 2001). Moreover, especially for young people with externalizing problems there seems to be a strong association between the quality of the client-therapist relationship and treatment outcomes (Shirk & Karver, 2003) and that is a group that is often represented in secure residential youth care (Bullock et al., 1998).

Specific treatment factors that are considered to be important for successful outcomes in residential youth care include a supportive, safe environment during care, specific treatment focusing on the individual needs of the young people during care, and aftercare services (Boendermaker, Van Rooijen, & Berg, 2010; Clough, Bullock, & Ward, 2006; Harder et al., 2006; Knorth, Harder, Zandberg, & Kendrick, 2008). Family-focused interventions are also considered as important for improving residential care outcomes (e.g., Geurts, Knorth, & Noom, 2008), although Clough et al. (2006) emphasize that whether and how families can be involved in the care process should be assessed for every individual child, because for some children the involvement of family might mainly have negative consequences. In addition, Stein (2008) mentions about young people leaving out-of-home care that "family relationship are often a major dilemma for many of these young people. They need and want to have a sense of family, not surprising given the centrality of 'the family' in ideology, policy and practice, yet many of these young people have been damaged by their family experiences" (p. 38).

## 1.5 The inside out of secure residential care

The empirical studies that are described in several of the following chapters in this book (chapter two, four, six and eight; see also Table 1.1) are part of the actual PhD project, which is carried out in secure residential care center *Het Poortje* in the Netherlands. Young people aged from 12 to 23 years old are placed in the center by either a civil or penal measure. The principal reason for admission is either intolerably disruptive and antisocial behavior or behavior presenting a danger to the young person him or herself or to the general public.

### 1.5.1 Pilot study

The PhD project in *Het Poortje* started with a pilot phase, which focused on the black box of the secure care center and was called “The inside out?” (Harder, Kalverboer, & Knorth, 2007). During this pilot study, the researcher worked with group care workers on the residential groups and with teachers in classes for a short period of time to see how it looks like for both the young people and the most important staff members to stay and work in the center. The project leader also interviewed eight adolescents and their parents, and eight group care workers and seven teachers working in the center about their experiences with the center during this participant observation period. Some of the remarks that were made during these interviews can be found at the start of several chapters in this book. The results of the pilot study were used for the design of the actual study, which results are presented in the following chapters of this book.

Results of the pilot study showed that the main components of care and treatment in the secure residential care center were activities at the residential group and special education in relatively small classes at the internal school. The results also showed that the care process was among others focused on enhancing the competence skills of the adolescents by using the social competence model (Durrant, 1993; Slot & Spanjaard, 1999), motivating the young people to change their behavior and improving the insight in their own behavior (Harder et al., 2007). Considering the composition of care in the secure residential center, we assumed that the care process mainly intervened with the problem awareness of the adolescents, their motivation for treatment, resistance and oppositional characteristics, and competence skills.

The group care workers and teachers that were interviewed during the pilot study mentioned several client factors that they considered as important for successful outcomes (Harder et al., 2007). These factors were mainly concerned with the adolescents’ behavior during their stay in the center, such as a good motivation for treatment, a high awareness of problems, an active attitude and a low level of resistance. They also considered the avoidance of antisocial friends as an important success factor.

### 1.5.2 Present study

The actual study, which is based on the results of the pilot study, consisted of a longitudinal design: A subgroup of all the 328 adolescents that entered the center between 1 September 2007 and 1 June 2008 was followed-up during and after staying in the center. The total research project consisted of interviews and questionnaires that were administered with the adolescents and their parents at admission ( $T_1$ ), eight weeks after admission ( $T_2$ ), at departure ( $T_3$ ) and one year after departure ( $T_4$ ). Also staff members within the secure care center (especially group care workers and teachers) were involved by completing several questionnaires at admission ( $T_1$ ), during the adolescent's stay ( $T_2$ ) and at the moment of departure ( $T_3$ ). A rough outline of the theoretical model of the present study is shown in Figure 1.3.

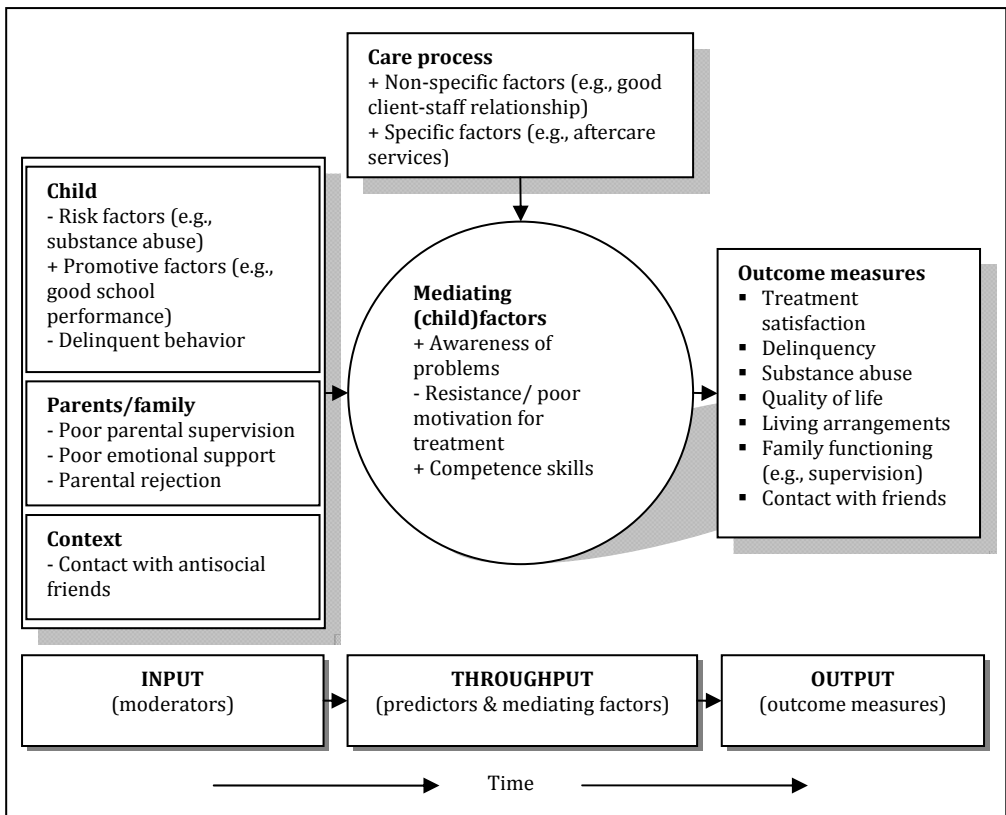


Figure 1.3  
Global theoretical model of the present study

Guideline for the research model is a division into “input”, “throughput” and “output” (cf. Van der Meulen, 1978; see also Veerman, Damen, & Ten Brink, 2000). The process of care can be described in terms of input, throughput and output. The input refers to the clients: the young people and their needs. In the present study, we will focus on several risk and promotive factors that are present with the young people (see Figure 1.3). The process of care can be described as throughput, and comprises all interaction of and between staff and clients during residential care. The present study will be focused on several non-specific and specific treatment factors that are believed to be especially relevant within the secure residential care context. The output refers to the results or proceedings of the care process: What is ultimately achieved with the young people and their parents? And how do they function after a period of residential care? (see also Harder et al., 2006). Since there is not much known about the outcomes of secure residential youth care except for recidivism, we will look at different outcomes that are measured both during and after the secure care period.

We assume that child, parents/ family and contextual factors that are present before admission (input – moderators) influence the functioning of the adolescents during their stay in the center (throughput – mediating factors) and the outcomes (output). The moderators can limit the potential effect of the care process. Our expectations with regard to the direction of influences are indicated by + (positive) and – (negative) signs in the figure. We assume, on the basis of the pilot study, that the care in the secure residential care center seizes upon the mediating child factors problem awareness, motivation for treatment and competence skills (Harder et al., 2007).

## **1.6 The downside up? Aims and outline of the present study**

Since an important intention of secure residential care is to meet the needs of young people, it is in the interest of these young people and their parents to increase the knowledge concerning factors that are associated with a successful course of treatment. It is also of public interest to gain a clear understanding of these success factors, given the seriousness of the adolescents’ problems, the high rates of recidivism, and the lack of knowledge about the (quality of) care that is offered in these settings. In addition, the high amount of costs that is associated with both the adolescents’ antisocial behavior and this type of care, and the negative image of (secure) residential care, stress the need for better insight into aspects of secure residential care that are important for success. By studying the performed care and treatment in practice and, hereby, paying attention to the general and specific treatment factors that are known from the literature, we can generate indications for improvements in care for this specific target group. By means of a better insight into the characteristics and problems of the young people on the one hand and the care

process on the other, a more adequate treatment can be realized by which the risk for future crime can be reduced and the public safety can be improved.

Therefore, the central aim of the present study is to gain a clear understanding of the factors that are of importance for an effective, residential treatment for adolescents with serious behavioral problems. More specifically, this study aims to examine client and care process factors that are associated with outcomes of (secure) residential care. In doing so, characteristics of the care process and the interaction between the care process and clients will be an important focus. The central question of the study is: Which factors are associated with a successful course of treatment for adolescents who are placed in secure residential care due to delinquent behavior and/or serious behavior problems?

To answer this question, both review studies and empirical studies on the process and outcomes of residential youth care are included. The review studies are partly based on a review study that was published in 2006 (Harder et al., 2006) and include empirical studies that have been carried out in the field of residential care. The empirical studies are part of the actual PhD project that was carried out in secure residential care center *Het Poortje*. To summarize, the structure of the book is shown in Table 1.1.

Table 1.1  
*Overview of studies included in this book*

Chapter	Literature review of (secure) residential youth care	Empirical study of secure residential youth care
1.		Introduction
2.		Characteristics of adolescents
3.	Client-care worker relationship	
4.		Adolescent-staff relationship
5.	Outcomes of care	
6.		Factors contributing to outcomes
7.	Outcomes of aftercare services	
8.		Outcomes after departure
9.		Conclusion

The central aim of **chapter two** is to examine relevant risk and promotive factors in the sample of adolescents staying in secure care center *Het Poortje*. It is important to increase the knowledge regarding the specific risks and needs of adolescents in secure residential care so that effective interventions can be implemented. Besides the prevalence of risk and promotive factors, the chapter focuses on differences in the number and type of risk and promotive factors between more and less problematic adolescents and on identifying subgroups showing specific combinations of risk factors. In studying risk and promotive factors, we used information that was collected at admission ( $T_1$ ) from treatment documents, interviews and questionnaires administered with the adolescents ( $N = 164$ ) and group care workers.

**Chapter three** is a review study that describes findings of empirical studies focusing on one specific aspect of the care process that is expected to be important in achieving positive outcomes: the relationship between clients and residential care staff (i.e., especially group care workers and teachers). The review is based upon an extensive literature search for (inter)nationally conducted empirical studies of this topic covering a period from 1990 up to February 2011. In describing the findings, we both focus on interactional processes between young people and staff, and parents and staff.

The aim of **chapter four** is to examine the quality of this client-staff relationship within the context of secure residential care, including factors that are important for this quality. Because both group care workers and teachers interact with the young people on a daily basis, we defined the client-therapist relationship in secure residential care as the relationship between group care workers and adolescents, as well as between teachers and adolescents (cf. Daniël & Harder, 2010). For this study, we used information from interviews and questionnaires administered with adolescents ( $N = 135$ ), group care workers and teachers at admission ( $T_1$ ) and eight weeks after admission ( $T_2$ ) to *Het Poortje*.

The outcomes of residential youth care are the central focus in **chapter five**, in which a meta-analysis will be described. Aim of the meta-analysis is to see if residential care is an intervention that can contribute to the positive development of youth with serious behavioral and/or emotional disturbances. In the meta-analysis, we report research of empirical outcome studies published in the period 1990-2005.

Which client factors and factors of the care process are associated with positive and negative outcomes of secure residential care is studied in **chapter six**. This chapter specifically focuses on both the risk factors that are present with the adolescents described in chapter two, and the factors that are important within the process of care, which are described in chapter three and four. For this study, we used information from treatment documents and information that was gathered at admission ( $T_1$ ), eight weeks after admission ( $T_2$ ) and at departure ( $T_3$ ) by instruments administered with adolescents, group care workers and teachers.

Since adolescents often have problems in their situation after leaving residential care, **chapter seven** specifically focuses on one of the aspects that is believed to improve the longer term outcomes, namely aftercare services or services following residential care. Although aftercare is recognized as an important aspect of residential youth care, there are indications that the provision of aftercare support is lacking in practice. Therefore, we examined what is known about the outcomes of services and professional support (e.g., outpatient mental health care, step-down services, community support) that young people receive after leaving residential care on the basis of empirical studies that were carried out (inter)nationally from January 1990 up to March 2010.



**Chapter eight** examines whether and how aftercare services and other factors in the context of adolescents that have left the care center are associated with outcomes one year after departure. Because outcomes of secure residential care are often viewed in terms of delinquent behavior and rarely in terms of other relevant outcomes, we assessed outcomes one year after leaving secure residential care in terms of the adolescents' quality of life, living conditions, and the functioning of their social context (i.e., family and friends). For this study, we used information from treatment documents and official records regarding information about the adolescents' delinquent behaviour ( $N = 199$ ) one year after departure, and interviews administered with a subgroup of adolescents ( $N = 26$ ) at admission ( $T_1$ ) and one year after departure ( $T_4$ ).

The book will be concluded by **chapter nine**, which comprises an overall discussion of the main findings that are described in the different chapters. By discussing all the findings, we try to get "the downside up" by pointing out what ingredients are important for improving the outcomes of (secure) residential youth care. Both the client and care process factors that are associated with the outcomes of (secure) residential care will be discussed. This chapter also describes the limitations and strengths of the present study and several recommendations for both the field of research and practice that emerge from the findings.